BROOMFIELD FAMILY PRACTICE MEDICAL RECORDS RELEASE FORM

1420 W Midway Blvd. Broomfield, CO 80020
Phone: 303-466-1866 Fax: 303-466-4081

Release Medical Records From:

_____
Doctor/Hospital

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

Send Medical Records To:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

Patient Information

_____
Print Patient's Full Name

_____
Street Address

_____
City, State, Zip Code

_____
Date of Birth (Month/Day/Year)

_____
Social Security Number

_____
Daytime Phone Number

Information to be released:

___ **I do** ___ **I do not** authorize the release of information related to **HIV/AIDS, psychological or psychiatric conditions,** and treatment for **alcohol and/or drug abuse**.

Release the following records:
____ 3 yrs. Medical records including progress notes & diagnostic results

____ Only some portion of records _____

____ I choose staff to determine and select pertinent records for transfer

Purpose of Disclosure:

___ Referral to Specialist ___ Permanent Transfer ___ Personal ___ Insurance
___ Workers Comp ___ Legal Investigation ___ Disability Determination

There will be a charge for a personal copy of your records
The fee schedule is: 1-10 pgs $18.53, 11-40 pgs .75 a pg, 41-100 .50 a pg, plus postage

This authorization is valid for 1 year from date of signature unless otherwise indicated: _____

Patient Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign and authorization form * To take part in a research study. * To receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: *Fill out a revocation for (available from our office) or written communication to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized signature **Date**

_____ _____
Printed name of patient or person signing on behalf of patient Relationship (self/parent/legal guardian/personal representative)

Written permission by the designated representative to receive records must be in representative's possession or on file in patient chart.
Minor's signature is required for release of any treatment which the minor may authorize und Colorado Law.